U.S. Department of Labor

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Issue date: 10May2002

In the Matter of:	:	
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MIKE KENNEDY,	:	
Claimant,	:	
	:	Case No.: 2000-BLA-43
v.	:	
	:	
EXPANSION COAL COMPANY,	:	
Employer,	:	
	:	
and	:	
	:	
DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,	:	
Party In Interest	:	

DECISION AND ORDER ON EMPLOYER'S REQUEST FOR MODIFICATION

Statement of the Case

This proceeding involves the Employer's request for modification of an award of benefits which was affirmed by the Benefits Review Board and by the United States Court of Appeals for the Sixth Circuit under the Black Lung Benefits Act, as amended, 30 U.S.C. §901 et seq. (hereinafter "the Act") and regulations promulgated thereunder.[1] Since this claim was filed after March 31, 1980, Part 718 applies. §718.2 Because the Claimant Miner was last employed in the coal industry in Kentucky, the law of the Sixth Circuit of the United States controls. (D-1, 2, 3) *See Shupe v.*

[1]All applicable regulations which are cited are included in Title 20, Code of Federal Regulations, unless otherwise indicated, and are cited by part or section only. The amendments to Part 718, published in Fed. Regis./Vol. 65, No. 245, Wed. Dec. 20, 2000, which became effective on Jan. 19, 2001, are applicable in accordance with their terms to this claim which was pending on the effective date of the amended regulations. Claimant's Exhibits are denoted "C-"; Director's Exhibits are denoted "D-"; Employer's Exhibits are denoted "E-"; and citations to the hearing transcript are denoted "Tr."

Director, OWCP, 12 BLR 1-200, 1-202 (1989)(*en banc*).[2] Claimant and Employer are represented by counsel. For the reasons enumerated hereinafter, the request for modification is denied.

Claimant Mike Kennedy filed his claim for black lung benefits on January 23, 1991. After a hearing, benefits were awarded by an Administrative Law Judge on January 7, 1993. The award was affirmed by the Benefits Review Board on October 27, 1994, and by the United States Court of Appeals for the Sixth Circuit on November 17, 1998. Employer petitioned the District Director for modification on or about February 23, 1999, with the accompanying submission of a medical opinion by Dr. Branscomb reflecting a review of specified medical records of the Claimant. On June 4, 1999, the District Director issued an order to show cause why the modification should not be granted based on the evidentiary submission suggesting a mistake in a determination of fact.

Claimant responded, in substance, that the petition for modification was based upon a negative physician's report that was cumulative, and that was not based on new evidence; that to grant the modification would not "render justice under the Act" as required; and that the finder of fact "must not lightly consider reopening a case at the behest of a party who, right or wrong, could have presented its side of the case at the first hearing." The gist of Claimant's position is that the petition is simply a device to perpetuate litigation of the claim and to relitigate a failed defense. Claimant opposed further discovery. Employer contends that, like any other party, it is entitled to unfettered consideration of its request for modification, including discovery and a medical examination of the Claimant, under applicable law and regulations. The District Director, after issuing an order to show cause and receiving responses from the parties, and after decrying perceived failings of the process, forwarded the claim to the Office of Administrative Law Judges for appropriate action (D-84, 85). The case is not in pay status. (D-85)

Request for Modification - Applicable Law

The Employer is entitled under settled law to consideration of its request for modification. *Branham v. Bethenergy Mines, Inc*., 20 BLR 1-28 (1996). On grounds of a change in conditions, or because of a mistake in a determination of fact, any party "may" at any time before the expiration of one year from the date of the last payment of benefits, or at any time before one year after the denial of a claim seek modification of the terms of an earlier award or denial of benefits. 33 U.S.C. §922; §725.310(a). Within the prescribed time limits Employer, like any interested party, may

[2]Judge Smith and the Benefits Review Board erroneously indicated that the claim was within the jurisdiction of the United States Court of Appeals for the Fourth Circuit. (D-43 at 19, 21, 24; D-66 at 3) The evidence shows that Claimant's last coal mine employment was for the Respondent Employer in McCarr, Kentucky. (D-2) That the error was harmless is implicit in the affirmation of the Benefits Review Board's decision, and indirectly the Administrative Law Judge's decision, by the United States Court of Appeals for the Sixth Circuit as "in accordance with law," and the absence from the record of any indication that the application of principles of law derived from Fourth Circuit authorities conflicted with the law of the Sixth Circuit or inappropriately affected the resolution of any issue or the outcome of the case.

allege, as it has in this case, a mistake in a determination of fact under §725.310 by mere general disagreement with the ultimate result of a disfavored determination in order to require reconsideration of the terms of the award.[3] However, modification is discretionary, not automatic, because the implementing regulation and the statute itself provide that a fact finder "may" reconsider the terms of any reward or denial. In deciding whether a case should be reopened, therefore, the reviewer must balance the need to render justice under the Act against the need for finality in decision making. *See General Dynamics Corp. v. Director, OWCP*, 673 F.2d 23 (1st Cir. 1982)(Modification barred because mistake of counsel regarding applicable law deemed not to have precluded Employer from raising claim in earlier proceeding); *McCord v. Cephas*, 532 F.2d 1377 (D.C. Cir. 1976).

Employer's right to modification is essentially defined under the statute and regulations by *Stiltner v. Wellmore Coal Corp.*, 22 BLR 1-37 (2000)(reconsideration *en banc*); *Selak v. Wyoming Pocohontas Land Co.*, 21 BLR 1-173 (1999); *see also McCord v. Cephas, supra*. The Supreme Court has concluded that the applicable statute is designed to permit a District Director to modify an award when there has been "a mistake in a determination of fact which makes modification desirable in order to render justice under the act." *Banks v. Chicago Grain Trimmers Ass'n*, 390 U.S. 459, 464 (1968); *see Blevins v. Director, OWCP*, 683 F.2d 139, 142 (6th Cir. 1982). Theoretically, an allegation of mistake should not be allowed to become a backdoor route to retrying a case because one party thinks that it can make a better showing on a second attempt. *See General Dynamics Corp v. Director, OWCP, supra; McCord v. Cephas*, 532 F.2d 1377, 3 BRBS 371 (D.C. Cir. 1976).

The discretionary nature of the modification process is tempered by consideration of whether a reopening will render justice under the Act. *O'Keeffe, supra*; *see Kinlaw v. Stevens Shipping & Terminal Co.*, 33 BRBS 68 (1999)(ALJ's exercise of authority and discretion to reopen case based upon mistake of fact requires consideration of competing equities to determine whether reopening case will indeed render justice). "The congressional purpose in passing the law would be thwarted by any lightly considered reopening at the behest of an employer who, right or wrong, could have presented his side of the case at the first hearing and who, if right, could have thereby saved all parties a considerable amount of expense and protracted litigation." *McCord v. Cephas*, 532 F.2d at 1381; *see Kinlaw v. Stevens Shipping & Terminal Co., supra* (ALJ's discretionary authority to reopen a case based on a mistake in fact requires consideration of competing equities in order to determine whether reopening the case will indeed render justice.)

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[3]Both the District Director and the Administrative Law Judge who have considered aspects of this request for modification have deplored the current state of the law which perpetuates litigation and frustrates closure of the claims process on the basis of mere nonspecific assertions of a mistake in a determination of fact. In this instance, notwithstanding the protracted litigation up to this point, Employer has engaged yet another pulmonary specialist to review medical records of the Claimant nearly a decade old that were previously before another Administrative Law Judge in order to generate an opinion addressing the ultimate issue decided by that Administrative Law Judge and conflicting with the award of black lung benefits disfavored by Employer.

The Sixth Circuit has supported invocation of the modification procedures where an Administrative Law Judge failed to consider the applicability of a regulatory and statutory presumption, *Y & O Coal Co. v. Milliken*, 200 F.3d 942 (6th Cir. 1999); where a claimant had mistakenly received black lung benefits for ten years, and justice would be served by ensuring that benefits would not be paid based on that error from the Black Lung Disability Trust Fund, *Jackson v. Director, OWCP*, 38 F.3d 121 (Table), 1994 W.L. 573915 (6th Cir. 1994); where an award of benefits based upon incorrect statements about the miner's coal mine employment history nevertheless led to an award of benefits, *York v. Director, OWCP*, 82 F.3d 419 (Table), 1996 W.L. 185796 (6th Cir. 1996). In this case, however, Employer has merely disagreed with the ultimate conclusion of the prior Administrative Law Judge's decision and order as affirmed, based on a medical opinion of a nonexamining physician who reviewed evidence previously available to the responsible adjudicators.

Thus, the opinion of Dr. Branscomb, which is based on previously submitted and considered evidence, is not necessary to the petition suggesting a mistake in a determination of fact. In this case, Judge Holmes ruled, "in the interest of justice" requiring evenhanded treatment of claimants and employers under applicable law, that Employer was entitled to require Claimant to undergo another physical examination by a doctor of Employer's choice and to respond to discovery calculated to generate additional evidence. Dr. Branscomb's opinion of itself, as Claimant correctly contends, does not establish a mistake in a determination of fact. There is no earlier opinion by Dr. Branscomb of record. Exploitation of the modification procedure in this case is, in effect, a backdoor route to retrying a case because it is apparent that Employer believes it can make a better showing on the second attempt. This case does not present a factual scenario wherein a physician who had rendered an opinion in the earlier proceeding has recanted that opinion and changed the medical conclusion. Nor is there any indication that an opinion from Dr. Branscomb was either solicited or offered by Employer prior to the request that modification proceedings be initiated. Employer has offered no explanation as to why Dr. Branscomb's opinion was not produced during the earlier proceeding. It merely seems to challenge the prior outcome and initiate relitigation of the claim by the dissatisfied Employer. Nor can it be said to establish that reopening the claim would serve the ends of justice under the Act. It is evident that such a determination must await the development of new evidence by Employer or a reanalysis of the old record or a combination of both, which effectively renders moot the issue of whether the record should be reopened.

The authority to request modification thus vests this tribunal as fact finder with "broad discretion to correct mistakes of fact, whether demonstrated by wholly new evidence, cumulative evidence, or merely further reflection on the evidence initially submitted." *O'Keeffe v. Aerojet-General Shipyards, Inc.*, 404 U.S. 254, 257 (1971); Branham, 20 BLR at 1-32. The requested physical examination would obviously be evidence that was not available at the time of the original hearing. *See Branham v. Bethenergy Mines, Inc.*, 21 BLR 1-80, 1-82-83 (1998). Section 725.310(b) expressly provides for the submission of additional evidence by any party. §725.310(b) Given the state of the law, Claimant's contention that Dr. Branscomb's opinion finding no pneumoconiosis could have been offered at the first hearing had it been sought is not enough to bar Employer from developing a new case to deliver a different and favorable result at the *de novo* hearing required by the modification process. The possibility that Employer could prove in repeated litigation of the

merits of the claim that it would be unjustly required to pay undeserved benefits under the Act appears to be all that is needed to render justice under the Act. *See Branham*, 21 BLR. Under such applicable law Judge Holmes' ruling cannot be said to be an abuse of discretion. Consequently, the evidence produced thereby cannot on that grounds be excluded, and, absent other grounds for exclusion which have not been established, is properly admitted into evidence. It is incumbent upon this tribunal, therefore, to review the record before it to ascertain whether there has been a mistake in a determination of fact, and, if so, to reconsider *de novo* the claim for black lung benefits. However, since Employer's allegation of a mistake in a determination of fact goes simply to the ultimate determination of Claimant's entitlement to benefits, the threshold determination as to the existence of a mistake in a determination of fact effectively merges into an open ended *de novo* review of the record on the merits.

Findings of Fact

Decision and Order of Administrative Law Judge Smith Awarding Benefits

In reaching his decision to award benefits which was issued on January 7, 1993, Judge Smith relied primarily on the results of the examination and medical opinion of Dr. Rasmussen, rather than the opinions of the several other physicians which he found less credible. Both the Benefits Review Board and the United States Court of Appeals for the Sixth Circuit, refusing under their respective mandates to reweigh the evidence, expressly affirmed Judge Smith's credibility determination regarding Dr. Rasmussen's diagnosis of pneumoconiosis, and approved Judge Smith's rejection of the opinions of Drs. Lane, Anderson, and Fino, since he gave greater weight to the opinions of treating and examining physicians because of their superior and more persuasive reasoning. *See Grizzle v. Pickands Mather & Co.*, 994 F.2d 1093, 1`097, 17 BLR 2-123, 2-128-29 (4th Cir. 1993). They also explicitly approved Judge Smith's rejection of the opinions of Drs. Dahhan and Vuskovich, who had examined the Claimant, and his assignment of determinative weight to Dr. Rasmussen's opinion that Claimant has pneumoconiosis. The Benefits Review Board declared, "Of the examining physicians, he [Judge Smith] permissibly accorded determinative weight to Dr. Rasmussen's opinion that Claimant suffers from coal workers' pneumoconiosis because he found it to be 'far better reasoned, more persuasive,' and supported by 'far more extensive testing and current medical literature,'" which was within the proper exercise of his discretionary province. (C-4; D-43 at 13) Judge Smith also cited Dr. Rasmussen's assertion based on medical authorities that the effects of coal mine dust exposure cannot be separated from those of smoking cigarettes, and, therefore, accepted Dr. Rasmussen's disagreement with the assertions of Drs. Dahhan, Vuskovich, Anderson, Lane, and Fino, that Claimant's disabling respiratory insufficiency is due only to cigarette smoking.

Judge Smith's determination that Claimant had established the existence of pneumoconiosis pursuant to §718.202(a)(1) depended upon the so-called "true doubt" rule, which was no longer valid by the time of appellate review of his findings, and was not a basis of the affirmances either by the Benefits Review Board or the Sixth Circuit. *See Director, OWCP, v. Greenwich Collieries*, 512 U.S. 267 (1994). (D-78, slip opinion at 4, n.4, 7) This change in the law is deemed to require a redetermination of whether Claimant has established the existence of pneumoconiosis pursuant to §718.202(a). *See Chester v. Hi-Top Coal Co.*, 21 BLR 1- (2001). In any event, such a

redetermination would be necessary under §718.202(a) pursuant to *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 22 BLR 2-162 (4th Cir. 2000). Judge Smith's determination that there was no basis for a finding of pneumoconiosis pursuant to §§718.202(a)(2) and (3) is clearly correct in the absence of requisite proof by the Claimant.

In concluding that Claimant had established the existence of pneumoconiosis pursuant to §718.202(a)(4), Judge Smith relied upon certain Fourth Circuit authorities for the proposition that the evidentiary weight accorded the medical opinions of nonexamining physicians is properly restricted where the nonexamining physician provides an opinion on a matter which was not addressed by other physicians whose reports the nonexamining physician relied upon. *See Turner v. Director, OWCP*, 927 F.2d 778, 15 BLR 2-6 (4th Cir. 1990); *Bethlehem Mines Corp. v. Massey*, 736 F.2d 120, 7 BLR 2-72 (4th Cir. 1984)(A nonexamining physician's opinion on matters not addressed by examining physicians is insufficient as a matter of law to rebut presumptions under §788.305 or §727.203, respectively.)[4] Noting that the gist of the Fourth Circuit decisions appeared to be based on the proposition that nonexamining physicians lack the measure of reliability that comes from medical treatment, examination and first hand observation. Judge Smith accorded greater deference to the examining physicians.[5] Of these he accorded deference to Dr. Rasmussen's opinion as "far

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[4]Judge Smith also referred to the first footnote in *Eagle v. Armco, Inc*., 943 F.2d 509, 15 BLR 2-201 (4th Cir. 1991), which noted "that our prior decisions have established that 'the testimony of a non-examining, non-treating physician should be discounted and is not substantial evidence when totally contradicted by other evidence in the record.' *Gordon v. Schweiker*, 725 F.2d 231, 235 (4th Cir. 1984); *see also Pitzer v. Sullivan*, 908 F.2d 502, 506 n.4 (9th Cir. 1990)('[T]he conclusion of a non-examining physician is entitled to less weight than the conclusion of an examining physician.') We have declined, however, "to say that the opinion of a doctor who has not examined or treated the claimant is never entitled to any weight." *Hayes v. Gardner*, 376 F.2d 517, 521 n.1 (4th Cir. 1967).

[5]This tribunal is aware of no authorities in the Sixth Circuit dealing with how much relative weight should be given to the opinions of nonexamining doctors under various circumstances. However, the Fourth Circuit has declared in *Grizzle v. Pickands Mather & Co.*, 994 F.2d 1093, (4th Cir. 1993), "that as a general matter the opinions of treating and examining physicians deserve especial consideration," but "[n]either this circuit nor the Benefits Review Board has ever fashioned either a requirement or a presumption that treating or examining physicians' opinions be given greater weight than opinions of other expert physicians." The Fourth Circuit has also noted with approval the Seventh Circuit holdings that "ALJs cannot afford more weight to an examining physician's opinion solely because that doctor personally treated the claimant," *Amax Coal Co. v. Beasley*, 957 F.2d 324, 327, 16 BLR 2-45 (7th Cir. 1992) and "[i]f the treating physician is not a specialist in black lung disease but the consultant is, and if the judgment of disability depends to a great extent on the expert interpretation of documentary data, such as x-rays and the results of gas and ventilatory tests, then reason may require that the consultant's opinion be given equal or even greater weight than the treating physician's," *Peabody Coal Co. v. Helms*, 901 F.2d 571, 573, 13 BLR 2-449 (7th Cir. 1990). *See Sterling Smokeless Coal Co. v. Akers*, 131 F.3d 438, 21 BLR 2-269, 2-275 (4th Cir. 1997)(A rule of absolute

better reasoned and more persuasive than the opinions of Drs. Dahhan and Vuskovich." He declared Dr. Rasmussen's testing far more extensive and his medical opinion to be supported by specified current medical literature. Both reviewing authorities found Judge Smith's conclusions to be adequately supported in this regard.

Likewise, Judge Smith found Dr. Rasmussen's opinion that Claimant was totally disabled by coal workers' pneumoconiosis to be better reasoned and more persuasive than the opinions of Drs. Dahhan and Vuskovich, who had been engaged by Employer, because Dr. Rasmussen's "testing was far more extensive and his medical opinion is supported by current medical literature as set out in his supplemental report." He discounted the consulting opinions of Drs. Lane, Anderson, and Fino that Claimant does not have coal workers' pneumoconiosis as less reliable than the opinions of examining physicians. (D-43 at 20; C-4) As noted by the Sixth Circuit, he also accorded greater weight to Dr. Rasmussen's opinion than those of Drs. Dahhan and Vuskovich, because Drs. Dahhan and Vuskovich did not understand the physical requirements of Claimant's relevant coal mining job duties. Both reviewing authorities found Judge Smith's conclusions to be adequately supported. The Sixth Circuit noted, however, that Judge Smith did not make an explicit finding that Claimant's total disability was caused by pneumoconiosis, but found the finding implicit based on his explicit subsidiary findings. (D-78, slip opinion at 5, 12-13) The Benefits Review Board explicitly affirmed Judge Smith's finding that Claimant's pneumoconiosis is at least a contributing cause to his total respiratory disability as supported by substantial evidence. The Benefits Review Board also noted that Judge Smith did not make a separate finding of causation with respect to §718.204(b), but held that he properly addressed the relevant opinions with respect to total respiratory disability and the etiology of the pulmonary impairment as required by cited case authorities, and within the limits of his proper exercise of discretion and the consistent application of his credibility analysis to all the evidence of record.

New Evidence Pertinent to Modification

Employer submitted two completely negative readings for pneumoconiosis by Drs. Wheeler and Scott, both board-certified radiologists and B-readers, of the January 19, 2000, x-ray film taken at the time of Dr. Garzon's examination detailed below. (E-2, 3) Claimant filed a nonconforming x-ray interpretation by Dr. Iko, a board-certified radiologist who is not identified as a B-reader, and who did not provide an ILO-U/C classification for his positive finding of "Radiographic features of

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deference to treating and examining physicians which relieves ALJ of statutory obligation to consider all of the relevant evidence, including opinions of nonexamining doctors, is reversible error.) The Fourth Circuit has also held that an Administrative Law Judge may not discredit a medical opinion solely because the physician did not examine the Claimant. *See Chester v. Hi-Top Coal Co.*, 22 BLR 1- (2001); *Milburn Colliery Co. v. Hicks*, 138 F.3d 524, 21 BLR 2-323 (4th Cir. 1998); *Sterling Smokeless Coal Co. v. Akers*, 131 F.3d 438, 21 BLR 2-269 (4th Cir. 1997). The Administrative Law Judge must provide an explanation or rationale as to why the fact that a physician did not examine the a claimant adversely affects the credibility of his opinion. *See Chester*.

coal workers pneumoconiosis and pulmonary fibrosis," as well as COPD and Pulmonary emphysema.[6] Claimant also submitted evidence of qualifying but nonconforming arterial blood gas studies and pulmonary function tests. (C-1) All of this evidence has been admitted into evidence. Employer also filed the consulting opinion of Dr. Branscomb, board-certified in internal medicine, the consulting opinion of Dr. Castle, board-certified in internal medicine and pulmonary disease, and the opinion of Dr. Garzon, board-certified in internal medicine, who examined the Claimant on January 19, 2000, approximately eight years after the most recent examination in the prior record. (E-1, 4)

Dr. Branscomb

Dr. Branscomb's seven page opinion dated January 25, 1999, introduced by Employer with the request for modification, reflects a review of specified medical data, including a review of the x-ray, pulmonary function and medical reports. Those data date back to Dr. Rasmussen's examination on February 11, 1991, and include subsequent evaluations by other physicians in early 1992. Dr. Branscomb concluded "[w]ith a high level of medical certainty and probability" that the Claimant "has not CWP nor any lung disease caused or aggravated by coal mine exposure," but he was "unable to rule out total disability of pulmonary origin." He concluded further that "[b]ased on the medical findings in the records any pulmonary disability is caused by cigarette and cigar smoking and possibly hiatus hernia but is not caused or aggravated by dust exposure." (D-79, exh. 1) Attached to the medical report is Dr. Branscomb's curriculum vitae which reflects board-certification in internal medicine, status as a B-reader, extensive academic and professional participation and recognition, as well as extensive publications, related to pulmonary diseases, but not board-certification in that subspecialty.

Dr. Branscomb analyzed Claimant's coal mine dust exposure, smoking history, medical history, chest examinations, chest x-ray interpretations, pulmonary function studies, arterial blood gas studies, and diagnoses by Claimant's personal physician, and Drs. Rasmussen, Dahhan, Lane, Anderson, Fino, and Vuskovitch obtained in 1991-92. There was no new evidence, and all the medical evidence Dr. Branscomb analyzed had been considered by Judge Smith. Dr. Branscomb concluded that Claimant's sixteen to eighteen years of exposure would be sufficient for a susceptible miner exposed to coal dust to acquire coal workers' pneumoconiosis (CWP). He opined that Claimant's pack a day cigarette and cigar smoking history of twenty-one years noted by Dr. Rasmussen to thirty years as noted by Drs. Dahhan, Lane, and Vuskovitch was sufficient for the common occurrence of smoking related pulmonary and cardiovascular disorders. Dr. Branscomb noted that Dr. Rasmussen, with whom he expressly disagreed, relied on a shorter, finite smoking history, extended by an occasional cigar, than other doctors had relied upon. Also, the other doctors noted continued smoking, and Dr. Branscomb noted that Claimant's 6.6% carboxyhemoglobin level on the date of his examination by Dr. Rasmussen was indicative of heavy continued smoking of much

[6]The record does not contain the credentials of Dr. Iko. However, this tribunal takes judicial notice of Dr. Iko's qualifications as listed on the worldwide web, American Board of Medical Specialties, Who's Certified Results, at http://*www.abms.org*. *See Maddaleni v. Pittsburgh & Midway Coal Mining Co.*, 14 BLR 1-135 (1990).

more than a pack a day. Dr. Rasmussen had not noted the significance of the carboxyhemoglobin level in his assessment.

Although Dr. Rasmussen concluded, based on medical literature, that "there was no way in which the effects of coal dust could clearly be separated from the effects of smoking and therefore [Dr. Rasmussen] attributed to coal dust some of the obstructive disease and resulting impairment," Dr. Branscomb insisted that "there is no objective way in which one can ascribe any of the impairments to coal dust in an individual patient as opposed to smoking." He declared that the research relating obstructive disease to coal dust exposure has been poorly controlled for cigarette smoking, and did not include examples of individual patients with function as severely reduced as this Claimant's. Dr. Branscomb opined that Claimant's "signs, symptoms, findings, and test values are absolutely typical of...COPD related to cigarette smoking."

Dr. Branscomb, noting that "the chest is usually negative in simple CWP," concluded that none of the physical examinations disclosed physical findings, including occasional expiratory wheezes, supporting a diagnosis of CWP or interstitial pulmonary disease. He opined that the wheezes were consistent with a mild intermittent asthma or asthmatic bronchitis typical of asthmatics and/or smokers. He also noted that two of the four positive x-ray readings out of a total of twenty-two readings were of the minimal classification, 1/0, and that the four positive readings were overwhelmed individually and cumulatively by negative readings by B-readers so as effectively to preclude a diagnosis of CWP. Dr. Branscomb noted that three doctors read the films as positive, ten as negative, and, was at pains to note that under the I.L.O. system a "positive" x-ray interpretation means that the reader concluded that changes were present which could be the result of one of the pneumoconioses among a number of possibilities other than CWP. He also noted that many readers noted possible emphysema, hyperinflation, or simply a large chest.

Dr. Branscomb opined that the arterial blood gas studies disclosed no significant hypoxia, but suggested heavy smoking. Four pulmonary function studies were deemed to have variable validity, partly due to Claimant's alleged furtive lack of cooperation. But he opined that they indicated sufficiently normal vital capacity measurements, corroborated by x-ray indicia of size or hyperinflation, to rule out restrictive disease, and to disclose treatable mild or moderate intermittent airways obstruction. Dr. Branscomb opined that these findings were consistent with bronchospasm typical of smokers, and not "a feature known to be associated with CWP."

In reviewing the diagnoses of record, Dr. Branscomb noted that Drs. Dahhan, Lane, Anderson, and Fino assessed disabling impairment related to cigarette smoking and unrelated to coal dust, and that Dr. Vuskovitch assessed chronic bronchitis attributable to cigarette smoking, but pulmonary function sufficient for coal mining. Dr. Branscomb expressly disagreed with Dr. Rasmussen's assessment of excessive ventilation on a demanding treadmill test which prevented further exercise for technical reasons having to do with the test measurement process and because Claimant's oxygen transfer tested normal with normal breathing. He also disagreed with Dr. Rasmussen's diagnosis of CWP based on a 1/0 x-ray interpretation, or three positive x-ray readings, and exposure history, because of the quality and quantity of negative x-ray interpretations of record, and because of Dr. Rasmussen's reliance on what Dr. Branscomb cited as defective research relating

obstructive disease to coal dust exposure. He noted that Dr. Rasmussen attributed Claimant's chronic bronchitis to both cigarettes and dust.

Dr. Garzon

In his report dated February 3, 2000, Dr. Garzon, who is board-certified in internal medicine, recorded work, family, and medical histories, conducted a physical examination and various medical tests on January 19, 2000. In significant contrast to prior histories Dr. Garzon recorded a ten to fifteen years one pack per day cigarette smoking history discontinued in 1980, somewhat less than the history relied upon by other opining physicians. He also noted an history of exposure to sawdust and rock dust. Dr. Garzon noted a contemporaneous nonconforming x-ray interpretation by Dr. Blankenship, a board-certified radiologist, which mentioned a lack of comparative studies, and noted hyperinflation of the lungs with flattening of the hemidiaphragms, and prominent linear radiopacity of the posterior central, right lung base, but did not mention pneumoconiosis, though it identified various abnormalities requiring follow up, and "Advanced COPD manifestations."[7] On physical examination he noted a fifty-six year old man, seventy and a half inches tall, no wheezes or rhonchi, decreased breath sounds, enlarged AP diameter of the chest. Dr. Garzon interpreted the pulmonary function studies as showing "a moderate restrictive, severe obstructive ventilatory impairment, with some improvement after inhalation of Albuterol." The blood gas studies, he indicated, revealed severe hypoxemia with FIO2 of 21.0."

Based on his studies, Dr. Garzon diagnosed "[c]hronic obstructive pulmonary disease with obstructive and restrictive ventilatory defect and moderate O_2 desaturation." He found evidence of significant pulmonary impairment shown by the pulmonary function studies, blood gas studies at rest, and the physical examination. He assessed advanced chronic obstructive pulmonary disease based on the chest x-rays, but found no radiological evidence of clinical coal workers' pneumoconiosis, and no medical evidence of a totally disabling chronic respiratory impairment arising out of coal dust exposure or coal mine employment. Dr. Garzon opined that Claimant has lost the functional capacity from the respiratory standpoint to return to his prior coal mine duties. (E-1)

Dr. Castle

In his consultative report dated May 11, 2000, addressed to Employer's counsel, Dr. Castle, who is board-certified in internal medicine and pulmonary disease, reviewed specified medical records. These included Dr. Garzon's recent examination report and x-ray interpretation, a recent blood gas study, and recent spirometric tests submitted by Claimant, in addition to the medical records from 1991-92, including x-ray interpretations, previously reviewed by Drs. Lane, Anderson,

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[7]The record does not contain the credentials of Dr. Blankenship. However, this tribunal takes judicial notice of Dr. Blankenship's qualifications as listed on the worldwide web, American Board of Medical Specialties, Who's Certified Results, at http://*www.abms.org*. *See Maddaleni v. Pittsburgh & Midway Coal Mining Co.*, 14 BLR 1-135 (1990). There is no evidence that he was a B-reader.

Fino, and Rasmussen, and the examination reports of the same period by Drs. Dahhan, Vuskovich, and Rasmussen. He opined that Claimant does not suffer from coal workers' pneumoconiosis, though there was sufficient underground coal mining exposure if he were susceptible. Dr. Castle opined that a thirty year smoking history, "[a]lthough he indicated to Dr. Dahhan that he had only smoked for ten or fifteen years, one pack per day," was sufficient to have caused chronic obstructive pulmonary disease in the form of chronic bronchitis/emphysema and/or lung cancer.[8]

Dr. Castle opined that Claimant at no time had any consistent findings indicating the presence of an interstitial process, as opposed to an obstructive process consistent with tobacco smoke induced COPD. He observed that the majority of x-ray interpretations were negative for pneumoconiosis, but noted evidence of pulmonary emphysema or COPD. Noting that when coal workers' pneumoconiosis causes impairment, it causes a mixed irreversible obstructive and restrictive ventilatory impairment, Dr. Castle opined that those pulmonary function studies that were not invalid disclosed evidence of some degree of obstructive airway disease without any evidence of a restrictive pulmonary process when lung volumes were done. He expressly noted in his conclusion that the Claimant "did not have any evidence of a restrictive process. Also he did have evidence on some occasions of a very significant degree of reversibility. That finding certainly goes against a diagnosis of coal mine dust induced lung disease," as opposed to significant tobacco smoke induced chronic obstructive pulmonary disease. He opined that the most recent arterial blood gas studies disclosed significant hypoxemia related to smoking, and that earlier studies done with exercise showed an increase in the pO_2 which militated against coal dust induced lung disease. (E-4)

Dr. Castle provided an opinion that was based upon the enumerated objective medical evidence before him, but it was not always clear in its reasoning. And in discussing Dr. Garzon's findings, and noting the defects of the related series of what he determined to be invalid spirometric tests, apparently reflecting less than maximal effort and obstruction of the mouthpiece which, he said, would artificially reduce forced vital capacity and preclude diagnosis of restriction. He concluded categorically that Claimant does not have the physical, radiographic, physiologic, or arterial blood gas findings to indicate the presence of coal workers' pneumoconiosis, and that Claimant's disability from tobacco smoke induced chronic obstructive pulmonary disease is not related in any way to his coal mining employment or coal dust exposure. (E-4)

Evidence Submitted and Considered Prior to Employer's Request for Modification

Dr. Fino

Dr. Fino's opinion of March 2, 1992, included review of Dr. Rasmussen's February 11, 1991, examination, Dr. Dahhan's July 30, 1991, examination, and various chest x-ray interpretations, and pulmonary function and blood gas test results. He concluded that the Claimant did not suffer from

[8]In fact, in reviewing the medical evidence in his narrative report Dr. Castle indicated that the Claimant gave Dr. Dahhan a thirty-pack-year smoking history, averaging a pack per day beginning at age nineteen, and currently continuing with mini-cigars. (E-4)

an occupationally acquired pulmonary condition resulting from coal mine dust exposure because the majority of the chest x-ray readings were negative for pneumoconiosis; there was no impairment in oxygen transfer because the Claimant did not become hypoxic with exercise; there was a pure obstructive defect present, which was not consistent with pneumoconiosis; and the reduction in diffusion was consistent with the obstructive abnormality which is consistent with emphysema. Dr. Fino explained that pneumoconiosis is an interstitial pulmonary condition causing fibrotic scarring which "will cause a restrictive ventilatory defect, not an obstructive ventilatory defect," when it causes abnormality in spirometry. Because there is no restriction, but pure obstruction, this argues against a coal dust related lung disease.

Dr. Fino noted further in describing the characteristics of pulmonary disease that "Coal mine dust inhalation does not cause a reversible narrowing of the breathing tubes. Coal mine dust inhalation causes an irreversible abnormality in the lungs which does not improve with bronchodilators . . . In addition, there is no good clinical evidence in the medical literature that coal mine dust inhalation in and of itself causes significant obstructive lung disease irrespective of its ability to be reversed following bronchodilators." He noted that the Claimant was still smoking, despite his denial, because he had allegedly told Dr. Dahhan in July 1991, that he was still smoking and he demonstrated elevated carboxyhemoglobin level to Dr. Rasmussen in February 1991. Dr. Fino found total pulmonary disability due to cigarette smoking. He concluded that pneumoconiosis was not present; that a disabling respiratory impairment due to cigarette smoking was present; that the effects of cigarette smoking can be distinguished from the effects of coal dust inhalation; and that the Claimant's condition was related to smoking, not coal dust inhalation. (E-4)[9]

Dr. Vuskovich

In an opinion dated March 23, 1992, Dr. Vuskovich, a physician engaged by Employer whose credentials are not of record, noted a thirty pack year smoking history allegedly ending six or seven months before his examination of the Claimant on March 14, 1992. The opinion was based upon a general physical examination, including histories, pulmonary function studies, and serum theophylline and comprehensive health profile blood tests. Although Dr. Vuskovich noted current administration of a bronchodilator medication, and basilar rales and wheezing throughout both lung fields, he diagnosed chronic bronchitis adequately treated, and, noting that Claimant had quit smoking approximately six or seven months before, opined that "with good effort, [the Claimant] would generate normal pulmonary function studies." He noted problematical pulmonary function studies, because the Claimant had difficulty performing with his false teeth, because the Claimant gave poor performance effort, and because Dr. Vuskovich purportedly observed the Claimant leaking air from the side of his mouth away from the doctor. Nevertheless he noted a mild obstructive impairment, and concluded that from a pulmonary standpoint Claimant would be capable of returning to his work in coal mines. In this regard he was at odds with all other medical opinions of record. He diagnosed chronic bronchitis, being adequately treated. (E-9)

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[9]Employer's Exhibits 1-12 are inserted in the file between Director's Exhibits 39 and 40, and retain the Employer's numbering.

Dr. Anderson

Dr. Anderson's short medical report dated February 27, 1992, was based upon a review of medical records supplied by Employer's attorney. Dr. Anderson surveyed thirteen chest x-ray readings, five positive, three classified 1/0, which he suggested reflected serious consideration to their being negative. The three sets of pulmonary function studies, Dr. Anderson opined, revealed a significant degree of obstructive ventilatory defect. Two sets of arterial blood gas studies included Dr. Rasmussen's at the lower limits of normal, and Dr. Dahhan's, which revealed a mild decrease in arterial pO_2 characteristic of obstructive ventilatory defect. In an earlier report dated July 23, 1991, Dr. Anderson, at the request of Employer's attorney, reviewed Claimant's pulmonary function studies performed for Dr. Rasmussen on February 11, 1991. (D-30) Dr. Anderson validated the studies as indicating a moderate obstructive ventilatory defect without any restrictive defect, usually caused by long term cigarette smoking

Dr. Anderson opined that "[i]t is medically feasible with any degree of medical certainty to distinguish between the pulmonary disability caused by cigarette smoking as opposed to that caused by exposure to coal mine dust. . . [and] to distinguish between this claimant's pulmonary disability caused by cigarette smoking as opposed to coal mine dust based on the medical evidence." He opined that "the origin of the pulmonary disability is due to his many years of cigarette smoking with in the degree of medical probability and/or certainty. Mr. Kennedy has pneumoconiosis to the extent of only category 1/1. In nonsmoking miners with category 1/1 pneumoconiosis the level of pulmonary function does not differ from that of miners with category 0/0 pneumoconiosis, and smoking miners have very much less pulmonary function in comparison to nonsmoking miners regardless of the level of simple pneumoconiosis. Thus, Mr. Kennedy does not have any impairment which has arisen from his coal mine employment due to the inhalation of coal dust, however he does not have the respiratory ability to perform the work of an underground coal miner due to his pulmonary emphysema as a consequence of cigarette smoking. The above can be stated with a high degree of medical certainty." Dr. Anderson's professional credentials of record are limited to a letterhead notation that his practice is concerned with occupational pulmonary diseases. (E-3)

Dr. Lane

Dr. Lane's opinion dated January 17, 1992, also reflected a review of medical evidence provided by Employer's lawyer. Dr. Lane noted nine chest x-ray interpretations, one of which , by Dr. Speiden, was positive, but contradicted by other readers "including radiologists and B-readers." The rest of the x-ray interpretations were negative for coal workers' pneumoconiosis. He construed Dr. Rasmussen's pulmonary function studies as showing partial reversal of an obstructive abnormality following administration of a bronchodilator. He construed Dr. Dahhan's studies as indicating no significant reversal of obstruction, but improved vital capacity after bronchodilator. He interpreted the resting arterial blood gases as demonstrating mild hypoxemia, with a rise in pO_2 with exercise. He noted eighteen years in underground coal mining, and a smoking history of a pack of cigarettes per day beginning at age nineteen, recently changed to "mini cigars." Based on the description of evidence and described assessments, Dr. Lane opined that there was no evidence that the Claimant has an impairment arising from coal mine employment or coal mine dust inhalation; but that he lacks

the respiratory ability to mine coal underground which is related to his chronic obstructive pulmonary disease secondary to his long smoking history. Dr. Lane's observation "that the first vital capacity was essentially normal. If there is a decrease of pulmonary function as a result of exposure to coal mine dust it may be a very mild restrictive impairment which would be manifested as a decrease in vital capacity. His predominant problem is decrease in his FEV1.0 which is consistent with an obstructive defect secondary to chronic obstructive pulmonary disease, a result of his long history of cigarette smoking." (E-2)

Dr. Rasmussen

Dr. Rasmussen's examination report dated February 11, 1991, supplemented by a more detailed narrative report, reflects a twenty-one year pack per day cigarette smoking history begun in 1961 and stopped in 1982, except that Claimant "[s]mokes occasional cigar now." He recorded sixteen or seventeen years underground coal mine employment, mostly at the face, principally as a roof bolter. The work involved some heavy labor pulling and carrying electrical cable, shoveling, carrying rock dust bags, and setting timbers. He noted on examination that breath sounds were minimally to moderately decreased, without rales, or rhonchi. He noted an increased expiratory phase and expiratory wheeze with forced respirations. Relying on Dr. Speiden's x-ray and its interpretation, Dr. Rasmussen diagnosed pneumoconiosis1/0 t/p all zones. He recorded ventilatory study results reflecting moderate, partially reversible obstructive ventilatory impairment; normal blood gases, and single breath carbon monoxide diffusing capacity (SBDLCO) minimally decreased, with DL/VA minimally decreased. An incremental treadmill exercise study together with the other studies indicated moderate loss of respiratory functional capacity as reflected by the ventilatory impairment sufficient to disable Claimant for his former coal mine employment with its requirement for some heavy manual labor.

Dr. Rasmussen, whose *curriculum vitae* records board-certification in internal medicine and board-qualification in pulmonary disease, as well as extensive professional involvement, including publications, with pulmonary and black lung disease, diagnosed coal workers' pneumoconiosis based upon seventeen years employment in the coal mining industry, deemed a significant history of exposure to coal mine dust, and the positive x-ray evidence consistent with pneumoconiosis reasonably attributable to Claimant's coal mine employment. He also diagnosed chronic bronchitis based on a history of chronic productive cough. He identified the etiology of the coal workers' pneumoconiosis as coal mine dust exposure and of the chronic bronchitis, coal mine dust exposure and cigarette smoking. Dr. Rasmussen opined that Claimant's pulmonary impairment prevented him from resuming his last regular coal mine job. In assessing the extent to which each of the diagnoses contributed to the impairment, Dr. Rasmussen declared, "The two risk factors are the patient's cigarette smoking and his coal mine dust exposure with its resultant CWP. Both can cause the abnormality found. The patient's CWP is at least a major contributing factor." In the narrative report he reasoned, "The two primary risk factors for the patient's totally disabling respiratory insufficiency appear to be his former cigarette smoking and his coal mine dust exposure with its resultant pneumoconiosis. Both could cause the same type and degree of abnormality encountered in this case. One must conclude that the patient's coal mine dust exposure is at least a major contributing factor to his totally disabling respiratory insufficiency." (D-18)

Dr. Rasmussen's opinion dated April 3, 1992, reflected a review of specified medical records pertaining to the Claimant. Dr. Rasmussen did not explicitly analyze specific records listed. Rather, he noted that Claimant was employed in the coal mining industry long enough to acquire coal workers' pneumoconiosis; that the positive and negative x-ray readings reflect a common conflict, especially where the profusion of abnormalities is relatively low; that the x-ray is an imperfect tool for determining the presence or absence of pneumoconiosis; that it is well known that pneumoconiosis may exist despite negative x-rays; and that there is no convincing medical evidence to suggest that extent of impairment depends upon the extent of x-ray shadows. Thus, Dr. Rasmussen opined that the positive readings of Drs. Ahmed, Speiden, and Pathak, all board-certified radiologists and B-readers, support a diagnosis of coal workers'' pneumoconiosis.[10]

In order to rebut the assertion by Drs. Dahhan, Vuskovich, Anderson, Lane, and Fino that the evidence in the case indicates that Claimant's disabling respiratory insufficiency is due only to cigarette smoking, because coal dust exposure produces a concomitant decrease in FVC and FEV_1, and that coal workers' pneumoconiosis is a "restrictive" lung disease, Dr. Rasmussen cites a variety of relatively contemporary studies, the gist of which is that coal dust exposure also causes significant airways obstruction such as disabling chronic bronchitis, reduced FEV_1, and centrilobular and focal emphysema, and that smoking increases the numbers of miners who suffer from the combined effects of inhalation of the two harmful substances, tobacco smoke and respirable coal dust. Dr. Rasmussen concludes from the cited material "that there is no way in which the effects of coal mine dust exposure could clearly be separated from those of smoking cigarettes," and that "[u]ndoubtedly, both cigarette smoking and coal mine dust exposure are contributing factors to Mr. Kennedy's disabling lung disease and one must therefore conclude that the coal mine dust exposure is at least a major contributing factor to his disability." (C-4)

Dr. Dahhan

Dr. Dahhan's report dated July 30, 1991, reflected a July 27, 1991, physical examination and testing. (D-31) He noted eighteen years of underground coal mine exposure in various capacities, and a pack a day cigarette smoking history beginning at age nineteen and continuing with mini-cigars. Dr. Dahhan recorded that arterial blood gases at rest showed minimum hypoxia; an exercise study showed normal values at its end. Spirometry, Dr. Dahhan indicated, showed a severe degree of airway obstruction with no demonstrable reversibility after bronchodilators. Claimant's chest x-ray showed hyperinflated lungs with depressed diaphragms, that is, changes consistent with emphysema. Dr. Dahhan opined that his review of the specified evidence disclosed no evidence of occupational pneumoconiosis or pulmonary disability secondary to coal dust exposure. Dr. Dahhan opined that

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[10]It is noteworthy that, although Dr. Speiden, a board-certified radiologist and B-reader, classified her findings with respect to the February 11, 1991, x-ray as 1/1 t/p, she stated in her narrative interpretation that "[t]he lungs show small irregular and nodular parenchymal densities bilaterally which could be classified as minimal or equivocal simple pneumoconiosis. No large opacitiies are seen here. . . .No localized area of infiltrate, consolidation, volume loss, or air trapping is seen. (C-3)

Claimant has chronic obstructive lung disease of the variety of chronic bronchitis and emphysema resulting from thirty pack years of smoking resulting in significant pulmonary impairment. Dr. Dahhan opined that Claimant does not have the physiological capacity from a respiratory standpoint to continue his previous coal mining employment because of his chronic obstructive lung disease.

Dr. Dahhan's medical report of September 2, 1991, responded to certain questions whose source is not identified. (D-35) In substance, Dr. Dahhan declared that it is medically feasible to distinguish between the pulmonary disability caused by cigarette smoking and that caused by exposure to coal mine dust both in the abstract and with respect to this Claimant. He opined that the origin of Claimant's pulmonary disability was a variety of specified symptoms indicative of chronic obstructive lung disease of the variety of chronic bronchitis/emphysema resulting from Claimant's smoking history. He opined that specified abnormalities characteristic of pulmonary disability secondary to coal dust exposure were absent. He declared that "Pulmonary disability secondary to coal dust exposure is manifested by restrictive impairment with the presence of crackles or crepitation on clinical examination of the lungs, restrictive abnormality on pulmonary function testing with normal FEV1-FVC ratio and reduction in both FEV1-FVC in a proportional manner, abnormality in the blood gas exchange mechanism that worsens after exercise, and the presence of fibrosis on chest x-ray." (D-35)

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Conclusions of Law and Discussion

The Claim of Total Disability Due to Coal Workers' Pneumoconiosis

Black lung benefits under the Act are awardable to persons who are totally disabled due to pneumoconiosis within the meaning of the Act. For purposes of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical," pneumoconiosis and statutory, or "legal," pneumoconiosis. §718. 201(a). Employer's request for a modification of the prior denial by Judge Smith suggests a mistake in a determination of fact because the claim is alleged to be wrongly decided. Employer has not alleged and the evidence of record does not suggest that there has been a change in conditions pursuant to §725.310.

Existence of Pneumoconiosis

Section 718.202(a) prescribes four bases for finding the existence of pneumoconiosis: (1) a properly conducted and reported chest x-ray; (2) a properly conducted and reported biopsy or autopsy; (3) reliance upon certain presumptions which are set forth in §§ 718.304, 718.305, 718.306; or (4) the finding by a physician of pneumoconiosis as defined in § 718.201 which is based upon objective evidence and a reasoned medical opinion. Proof of the existence of pneumoconiosis requires consideration of "all relevant evidence" under §718.202(a), as specified in the Act. *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 22 BLR 2-162, 2000 WL 524798 (4th Cir. 2000) Thus, if a record contains both relevant x-ray interpretations and physicians' opinions, the Act would prohibit a determination based on the x-ray evidence alone, or without evaluation of any physicians'

opinions, for instance, that the miner suffered from "legal" pneumoconiosis. *See Penn Allegheny Coal Co. v. Williams*, 114 F.3d 22, 21 BLR 2-104 (3d Cir. 1997).

Judge Smith found that the existence of pneumoconiosis was established by the x-ray evidence pursuant to the now invalidated "true doubt" principle, as well as by the reasoned medical opinion of Dr. Rasmussen under §718.202(a)(4). Specifically, Judge Smith found Dr. Rasmussen's opinion more credible than those of several other doctors, because it was based on a broader range of objective tests and more persuasive reasoning. Recognizing the invalidity of Judge Smith's finding under §718.202(a)(1) because of the change in the applicable law, the Benefits Review Board affirmed Judge Smith's finding that the evidence of record was sufficient to establish the existence of pneumoconiosis under §718.202(a)(4), as supported by substantial evidence, and the Board in turn was affirmed in this regard by the United States Court of Appeals for the Sixth Circuit. However, in reviewing the record for a mistake in a determination of fact, this tribunal must determine whether the Claimant has established the existence of pneumoconiosis pursuant to §718.202(a) in accordance with *Compton.*

The x-ray evidence of record does not establish that the Claimant has pneumoconiosis by the requisite preponderance under §718.202(a)(1). However, no claim for benefits may be denied solely on the basis of a negative chest x-ray. §718.202(b). There is no biopsy evidence of record, and the presumptions under §§718.304, 718.305, and 718.306 are inapposite because there is no evidence of complicated pneumoconiosis, the claim was filed after 1981, and because the miner is living. A determination of the existence of pneumoconiosis may be made pursuant to §718.202(a)(4) if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in §718.201. Any such finding must be based on objective medical evidence such as blood-gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories, and be supported by a reasoned medical opinion.

This tribunal is not bound to accept the opinion or theory of any given medical officer, but may weigh the medical evidence and draw its own inferences. *Lafferty v. Cannelton Industries, Inc.*, 12 BLR 1-190 (1989); *Kertesz v. Crescent Hills Coal Co.*, 8 BLR 1-112 (1985); *see Markus v. Old Ben Coal Co.*, 712 F.2d 322, 326, 5 BLR 2-130, 2-136 (7th Cir. 1983). A reasoned medical opinion is one in which the physician sets forth the evidence he relies upon in reaching his conclusion. *Fields v. Island Creek Coal Co.*, 10 BLR 1-19 (1987). In making this determination, this tribunal must "examine the validity of the reasoning of a medical opinion in light of the studies conducted and the objective limitations upon which the medical opinion or conclusion is based." *Director, OWCP, v. Siwiec*, 894 F.2d 635, 639, 13 BLR 2-259 (3d Cir. 1990). A well reasoned opinion is defined as one in which the documentation as a whole supports the physician's conclusions. *Phillips v. Director, OWCP*, 768 F.2d 892, 8 BLR 2-16 (8th Cir. 1985).

New Evidence Pertinent to Modification

Given the explicit scrutiny of Judge Smith's opinion at two levels of appeal, the new evidence

of record provides the primary basis for identification of any possible mistakes in Judge Smith's determinations of fact that would support Employer's request for modification. All of the evidence of record has been subjected to scrutiny by this tribunal for a possible mistake in a determination of fact, effectively a redetermination of the claim on the merits. Because there is a substantially greater number of negative than positive x-ray readings by qualified readers in the evidentiary record, this tribunal finds that the existence of pneumoconiosis has not been established by a preponderance of the x-ray evidence of record. Employer's completely negative readings for pneumoconiosis by Drs. Wheeler and Scott, both board-certified radiologists and B-readers, of the January 19, 2000, x-ray film taken at the time of Dr. Garzon's examination do not alter this conclusion. (E-2, 3)

Nor does Claimant's nonconforming x-ray interpretation by Dr. Iko, a board-certified radiologist who is not identified as a B-reader, and who did not provide an ILO-U/C classification for his positive finding of "Radiographic features of coal workers pneumoconiosis and pulmonary fibrosis," as well as COPD and pulmonary emphysema. Claimant's evidence of qualifying but nonconforming arterial blood gas studies and pulmonary function tests have limited probative value, since their significance has not been explained. To the extent that they reinforce proof of the existence of a disabling pulmonary impairment, they are essentially cumulative. (C-1) The consulting opinions of Dr. Branscomb, and Dr. Castle, and the opinion of Dr. Garzon, who examined the Claimant on January 19, 2000, roughly eight years after the most recent examination in the prior record, do not differ significantly , for the most part, from the opinions and ultimate conclusions of the five doctors previously engaged by Employer. (E-1, 4) No treating physicians are involved. Virtually all of Employer's physicians have found no pneumoconiosis and no causal relationship between coal mine dust exposure and the Claimant's pulmonary condition, although their reasoning, and in various respects their conclusions, vary considerably.

Dr. Branscomb's opinion, initially introduced by Employer to support the petition for modification, is based upon ten year old evidence, which was before Judge Smith. Since it is not based on any new evidence, it simply reflects the opinion of an expert belatedly engaged by Employer who presumably could have produced the opinion, had Employer sought it, in relation to the original proceeding. The opinion is tantamount to an opinion that the distinction can be made between the effects of coal mine dust exposure and cigarette smoking upon the Claimant, because the effects of coal mine dust are restrictive, while the effects of smoking are obstructive. This assessment is consistent with the expressed opinion of Dr. Fino, discussed below, who opined that it is medically possible to distinguish the effects of cigarette smoking from the effects of coal dust inhalation, and that pneumoconiosis would cause a restrictive, not an obstructive, ventilatory defect, and that Claimant's impairment was purely obstructive. Dr. Branscomb's opinion, therefore, like Dr. Fino's, runs afoul of the rubric of *Warth*, as limited by *Stiltner*.[11] Moreover, Dr. Branscomb's peremptory

[11]*Warth v. Southern Ohio Coal Co.*, 60 F.3d 173, 19 BLR 2-265 (4th Cir. 1995) "held that an administrative law judge may not rely on an opinion where the physician based that opinion on the erroneous assumption that obstructive disorders cannot be caused by coal mine employment." In *Stiltner v. Island Creek Coal Co.*, 86 F. 3d 337, 20 BLR 2-246 (4th Cir. 1996) the majority held that medical opinions indicating that an individual with a respiratory impairment

dismissal of the studies contained in medical literature upon which Dr. Rasmussen relied is not convincing or apparently dispositive, as the fact that those studies might have been flawed in some respects does not necessarily invalidate them wholly for Dr. Rasmussen's purposes. In addition, it is not clear why Dr. Branscomb's opinion is equivocal with regard to the existence of a totally disabling pulmonary impairment in the face of virtual consensus among the opining physicians. (D-4, 43) Therefore, for all these reasons, Dr. Branscomb's opinion is given little probative weight.

Dr. Castle's unexplained statement, based on a review of medical records, that, despite sufficient coal dust exposure, there was no restrictive pulmonary process, and that there was a very significant degree of reversibility, conflicts with Dr. Garzon's recent findings of moderate restrictive and severe obstructive ventilatory impairment, and limited effect of a bronchodilator, which Dr. Castle purportedly reviewed. Dr. Castle characterized Dr. Garzon's pulmonary function studies as invalid from lack of effort and from obstruction, though Dr. Garzon expressed no such reservations. To the extent that Dr. Castle's opinion in this regard is accepted, it would tend to reduce the credibility of Dr. Garzon's opinion in general, and with respect to his findings based on those studies, of a moderate restrictive impairment, as well as a severe obstructive impairment. Dr. Castle also declared that coal workers' pneumoconiosis causes a mixed irreversible obstructive and restrictive ventilatory impairment. Dr. Fino declared in his report, which Dr. Castle purportedly reviewed "in detail," that pneumoconiosis will cause a restrictive ventilatory defect, not an obstructive ventilatory defect. These opinions are not reconciled by Dr. Castle. Neither is Dr. Castle's observation that the apparently significant element of reversibility of the obstructive impairment was not consistent. He pointedly noted that there was evidence on some occasions of very significant reversibility, but does not account for the partial reversibility which, for instance, Dr. Lane opined was disclosed by Dr. Rasmussen's studies in February 1991, or Dr. Dahhan's finding in July 1991 of severe airway obstruction with no demonstrable reversibility after bronchodilators. Dr. Castle's generalizations regarding the alleged invalidity of the several tests of record are not helpful under such circumstances, and these factors all significantly reduced the persuasiveness of his opinion.

The analysis by Dr. Garzon, who is not shown to be a pulmonary specialist, reflects recorded attention to appropriate histories, various medical testing, and general physical examination. He recorded an apparently understated cigarette smoking history of ten to fifteen years, one pack per day, discontinued in 1980. His diagnosis of "Chronic obstructive pulmonary disease with obstructive and [re]strictive ventilatory defect and moderate O_2 desaturation," apparently does not relate to coal workers' pneumoconiosis. His finding of no radiological evidence of pneumoconiosis would relate only to clinical pneumoconiosis. His finding of no medical evidence of a totally disabling chronic respiratory impairment arising out of coal dust exposure or coal mine employment is not well reasoned in that he does not explain his conclusions or relate them to particular objective evidence. He did not disclose affirmatively what indications he was looking for; he did not explain how the particular objective evidence supported his conclusions; he did not opine affirmatively as to causation for any of the apparent abnormalities he identified; he did not address any possible effects of smoking;

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would likely exhibit a restrictive component if coal dust exposure were a factor are not necessarily inimical to the Act.

and he was unable to diagnose the prominent radiopacity in Claimant's lung without further follow-up studies. Nor did he explain the significance, if any, of the moderate restrictive ventilatory impairment, a condition the presence or absence of which was considered a significant indicator of coal dust impairment by other opining physicians of record. There is no indication that he reviewed any of Claimant's medical records. His examination of the Claimant was conducted on January 19, 2000, approximately eight years after Dr. Rasmussen's, but his opinion does not reflect a review of or comparison with any of the Claimant's medical records. Since various aspects of the opinion are questioned by Dr. Castle, and since there is no evidence that Dr. Garzon is a pulmonary expert, his opinion is given relatively little weight. Consequently, neither the opinion, nor the new evidence as a whole, provides a convincing basis for a finding of a mistake in a determination of fact, or, a change of conditions.

Old Evidence Pertinent to Modification

Reconsideration of the evidence that was before Judge Smith, separately and in relation to the new evidence, does not disclose any mistake in a determination of fact or compel a different outcome. Judge Smith's invalid finding of the existence of pneumoconiosis under §718.202(a)(1) pursuant to a subsequently invalidated legal standard, and this tribunal's finding that the x-ray evidence does not support a finding of the existence of pneumoconiosis, does not require a different outcome when all the relevant evidence considered under §718.202(a) is weighed together under the rubric of *Compton*. The Benefits Review Board approved Judge Smith's bestowal of determinative weight upon Dr. Rasmussen's opinion that the Claimant suffers from coal workers' pneumoconiosis because Judge Smith found that opinion to be "Far better reasoned, more persuasive," and supported by "far more extensive testing and current medical literature," and because Judge Smith "properly applied the principle articulated by the United States Court of Appeals for the Fourth Circuit" in *Grizzle v. Pickands Mather & Co*, 994 F.2d 1093, 1097, 17 BLR 2-123, 2-128-129 (4th Cir. 1993) that "as a general matter, the opinions of treating and examining physicians deserve especial consideration."[12] This tribunal finds no mistake of fact in Judge Smith's determination and concludes, likewise, that Dr. Rasmussen's opinion is most persuasive because of the quality of its reasoning and the scope of the objective evidence upon which it was based. Though more recent, Dr. Garzon's opinion is not better reasoned, nor is the objective evidence developed by Dr. Garzon more substantial than the evidence upon which Dr. Rasmussen relied. The reasoning in Dr. Branscomb's and Dr. Castle's opinions is not demonstrably more credible than Dr. Rasmussen's; Dr. Branscomb's qualifications as board-certified in internal medicine with a pulmonary specialty are approximately comparable to Dr. Rasmussen's, and Dr. Castle's board-certification in the subspecialty of pulmonary disease does not give him a significant edge in qualifications over Dr. Rasmussen or Dr. Branscomb in the context of this case.

This tribunal, like Judge Smith, finds the other physicians' opinions of record regarding the existence of pneumoconiosis less persuasive than Dr. Rasmussen's. Likewise, this tribunal finds Dr.

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[12]The Benefits Review Board's mistaken declaration at p. 3 of the Decision and Order that appellate jurisdiction of the case arose in the Fourth Circuit has been previously noted.

Rasmussen's opinion more persuasive than the other opinions as to the causal relationship of the pulmonary impairment, which Dr. Rasmussen attributed in substantial part to coal mine dust exposure as well as to the effects of Claimant's extensive smoking history.

Dr. Fino's opinion, though reasoned and based upon objective evidence which he reviewed in detail, runs afoul of *Warth* and *Stiltner*, which were issued in 1995, because of Dr. Fino's categorical conclusion that the absence of restrictive effect virtually excludes the existence of pneumoconiosis. His opinion suggests no consideration of the possible existence of "legal," as opposed to clinical, pneumoconiosis. Consequently, the reliability of Dr. Fino's opinion is substantially reduced. Certain of Dr. Vuskovich's findings are also inconsistent with the credible findings and opinions of record by all the other doctors. The absence of explicit reasoning to support his diagnostic conclusions significantly reduces the credibility of his opinion. The *ex cathedra* opinion of Dr. Anderson is tautological and unpersuasive. Proof of the doctor's credentials is limited, the basis for his stated assumptions is neither evident nor intuitive, and is not shown to reflect a consensus. In addition, what purports to be reasoning is hardly convincing.

The uncompromised dependence of his diagnosis upon the absence of restrictive impairment as an essential component of coal workers' pneumoconiosis brings Dr. Dahhan's opinion into stark conflict with the rubric of *Warth,* and vitiates any reliability of his opinion. Dr. Dahhan's opinion does not take account of "legal" pneumoconiosis because of the narrow scope of his definition of the characteristics of the disease. Dr. Dahhan does not disclose his reasoning which would connect the medical phenomena described with his conclusions, and merely states that he bases his opinion on his overall evaluation of the Claimant. Thus, it cannot be considered to be a reasoned opinion, although it contains a recital of his observations based upon the physical examination and testing.

Given the variations and inconsistencies among the several physicians' opinions in regard to their assessments of the evidence, their reasoning, and their conclusions, this tribunal finds no proof of a mistake in a determination of fact in Judge Smith's opinion as it was affirmed by the Benefits Review Board and the United States Court of Appeals for the Sixth Circuit. Moreover, in contrast to the various other opinions of record, this tribunal finds Dr. Rasmussen's findings with regard to the existence of pneumoconiosis and the contributing effects of coal mine dust exposure to Claimant's disabling pulmonary impairment, as well or better reasoned than any other opinion, and based upon adequate objective evidence. There was almost unanimous agreement among the physicians whose opinions are of record that Claimant is totally disabled by a pulmonary impairment. Consequently, Employer's request for modification of the prior denial should be denied, and the prior award of black lung benefits to this Claimant should be affirmed.

ORDER

Employer's request for modification of the award of black lung benefits to the Claimant Michael Kennedy is denied.

A
EDWARD TERHUNE MILLER
Administrative Law Judge